PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2003-D5

PROVIDER – Always Better Care Home Health Providers, Inc.
Los Angeles, CA

Provider No. 05-8017

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/ United Government Services, LLC-CA

DATE OF HEARING -
March 25, 2002

Cost Reporting Period Ended
July 31, 1998

CASE NO. 00-3145

INDEX

ISSUE:

Was the Intermediary's adjustment of start-up costs proper?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Always Better Care Home Health Providers, Inc. ("Provider") is a for-profit, freestanding home health agency ("HHA") located in Los Angeles, California. The Provider was licensed by the State of California in December of 1996, performed its first patient visit on January 8, 1997, and became certified for participation in the Medicare program on July 7, 1997. For the fiscal year under appeal, the Provider reported start-up costs of $325,914 on its Medicare cost report and claimed amortization expense of $70,615 as the amount of allowable start-up costs for Medicare reimbursement purposes. The total amount of allowable start-up costs reported by the Provider consisted of the accumulation of those costs incurred in developing the Provider's ability to furnish patient care services up to the date of Medicare certification on July 7, 1997.

Based upon its audit of the Provider's Medicare cost report, Blue Cross and Blue Shield Association/United Government Services (Intermediary") reduced the total amount of reported start-up costs to $102,990. The Intermediary made this adjustment to eliminate start-up costs incurred after the date of the first patient treatment on January 8, 1997, pursuant to § 2132 et seq. of the Provider Reimbursement Manual ("HCFA Pub.15-1"). The disallowance of start-up costs incurred during the period between the dates of January 8, 1997 and July 7, 1997 reduced the amount of claimed amortization expense to $22,315. Accordingly, the amount of Medicare reimbursement in controversy is approximately $48,000 for the fiscal year in controversy (99.52 percent Medicare Utilization).

The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by John W. Jansak, Esquire, of Harriman, Jansak & Wylie. The Intermediary's representative was James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's disallowance of accumulated start-up costs for the period between the first patient visit on January 8, 1997 and the date of Medicare certification on July 7, 1997 was improper. While it is the Intermediary's position that the accumulation of start-up costs cannot continue after the first patient visit, the Provider argues that the manual provision at HCFA Pub. 15-1 § 2132.2 permits the following three separate options as to when start-up costs can end:

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[1] All other issues appealed in this case have been administratively resolved or withdrawn by the Provider.

(1) The time the first patient is admitted for treatment, or

(2) The time the nonrevenue-producing patient care functions are used for their intended purpose, or

(3) The time the non-allowable functions are used for their intended purpose.

The Provider maintains that, prior to June 30, 1976, only the first option (patient admission) was applicable to HHA's.[2] The two additional options were added to the manual provision with Revision Transmittal No. 158 which amended HCFA Pub. 15-1 § 2132.2 in June of 1976. Accordingly, the Intermediary's position that only the first option was applicable ignores the two additional options available under the existing manual provision.

The Provider points out that the Medicare program requires a HHA applicant to be rendering skilled home services to a minimum of ten patients before a Medicare certification survey can occur. The Provider advises that it met this requirement in February of 1997, and the California Department of Health was requested to perform its survey at that time. However, the survey did not occur until July, and official certification was not established until July 7,1997. Since the Medicare regulation at 42 C.F.R.
§ 431.108(b) states that Medicare certification occurs when the onsite survey is completed, it is the Provider's position that all costs incurred before that date are non-allowable. This position is further supported by paragraph 6.23 E of the Intermediary Manual – Audit Procedures ("HCFA Pub. 13-4") which states:

> Verify that start-up costs do not include services provided to Medicare patients prior to certification.

The Provider believes that this audit instruction in HCFA Pub.13-4 clearly shows that some start-up costs can be allowed prior to Medicare certification even though patients are being treated. This instruction is also consistent with the third option available under HCFA Pub.15-1 § 2132.2. Despite the clear instructions set forth in the regulations and manual instructions, the Intermediary ignored the third option and disallowed the start-up costs incurred prior to Medicare certification that were non-allowable because the Provider was not able to carry out its normal patient services under the Medicare program's certification rules.

The Provider concludes that the Medicare program is required to follow its rules and instructions, and that it was arbitrary and capricious for the Intermediary to ignore such provisions in making its audit determination. The Intermediary's denial of non-allowable start-up costs before Medicare certification violates the anti-subsidization rules under Medicare law and regulations, and should be reversed by the Board.

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[2] See Provider Exhibit J.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly applied the provisions of HCFA Pub. 15-1 § 2132 et seq. in reducing the amount of start-up costs reported by the Provider. Start-up costs are defined in the manual instructions as those costs incurred in developing the provider's ability to furnish patient care services up to the date the provider sees its first patient. In describing the treatment of start-up costs for providers entering the Medicare program after operations have begun, HCFA Pub. 15-1 § 2132.3 instructs intermediaries to determine the correct 60-month amortization period starting with the date start-up costs are first incurred and ending on the date the first patient is seen. For example, where a provider enters the Medicare program thirty months after it sees its first patient, only the remaining thirty months of amortization will be includible on the provider's Medicare cost report. The Intermediary argues that the manual instructions are equally applicable to the total amount of start-up costs reported by the Provider in the instant case. If the Provider cannot claim the amortized start-up costs for periods after the first patient is seen and before Medicare certification, then it follows that the Provider cannot continue to accumulate start-up costs after the date the first patient is seen.

The Intermediary contends that the Provider has misread the manual instructions which discuss the treatment of start-up costs that apply only to nonrevenue producing or non-allowable functions of a provider's operations. Contrary to the Provider's position, the start-up costs at issue do not relate to nonrevenue or non-allowable functions. The services a home health agency performs (home visits) are revenue-producing functions which are billable and generate a charge on the provider's books. The fact that the Provider in the instant case generated no revenue from Medicare visits prior to Medicare certification does not render the home care function as nonrevenue producing. With respect to non-allowable functions, the Intermediary argues that this category relates to functions that will not change based on whether the service was performed before or after Medicare certification. A non-allowable function (i.e., doctors' offices or swimming pools) is always non-allowable by virtue of its nature, and the characterization is dependent on when it is provided to the patient. The Intermediary further argues that the Provider cannot limit the intended purpose of a home health agency to "Medicare visits" merely because most of its business would pertain to the Medicare program. The purpose of the Provider's home health agency was to provide home health care to patients regardless of who pays for the services.

In summary, the Intermediary believes that the Medicare program provides clear and specific instructions for the treatment of start-up costs, including the start and end date for accumulating start-up costs. The Provider in the instant case should have anticipated the need to see the requisite number of patients prior to the Medicare certification survey. To the extent that the Provider did not coordinate the survey process, the costs of seeing patients prior to certification must be considered a cost of doing business.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS

1. Regulations – 42 C.F.R:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 431.108(b)	-	Effective Date of Provider Agreements – Date of Survey

2. Program Instructions – Intermediary Manual - Audit Procedures (HCFA Pub.13-4):

Paragraph 6.23E	-	Verification of Start-Up Costs

3. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub.15-1):

§ 2132 et seq.	-	Start-Up Costs
§ 2132.1	-	Start-Up Costs – General
§ 2132.2	-	Start-Up Costs - Applicability
§ 2132.3	-	Start-Up Costs- Cost Treatment for Medicare Reimbursement

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post-hearing briefs, finds and concludes that the Intermediary properly applied the provisions of HCFA Pub. 15-1 § 2132 et seq. in determining the amount of start-up costs reimbursable under the Medicare program.

The manual provision at HCFA Pub. 15-1 § 2132.1 defines start-up costs as those costs incurred in the period of developing a provider's ability to furnish patient care services (exclusive of organizational or capitalizable costs). With respect to applicability, HCFA Pub. 15-1 § 2132.2 states that start-up costs are incurred from the time preparation begins . . . to the time the first patient, whether Medicare or non-Medicare, is admitted for treatment . . . . The Board finds that these manual provisions provide clear and specific instructions as to the start and end date for the accumulation of start-up costs.

The record shows that the Provider performed its first patient visit on January 8, 1997 and became certified under the Medicare program on July 7, 1997. Accordingly, the Board finds that the Provider became operational as a HHA on January 8, 1997 and, thus, the accumulation of start-up costs ceased as of that date. The fact that the Provider became Medicare certified on July 7, 1997 does not postpone its HHA operational status with respect to the provision of patient care services. The costs incurred between the period of

January 8, 1997 and July 7, 1997 were operational costs associated with patient care services and cannot be treated as start-up costs under the Medicare program.

The Board finds no basis for the Provider's argument that the HHA should be treated as a nonrevenue producing or a non-allowable function merely because the operational HHA had not commenced participation in the Medicare program. The Provider cannot limit the operational status of a HHA solely to the performance of patient care services for Medicare beneficiaries. The Provider has misinterpreted and misapplied the governing manual provisions at HCFA Pub. 15-1 § 2132 et seq. .

DECISION AND ORDER:

The Intermediary's adjustment resulted in the proper determination of the Provider's start-up costs. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary B. Blodgett, D.D.S.

DATE OF DECISION: November 21, 2002

FOR THE BOARD

Suzanne Cochran, Esquire
Chairperson